Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ANDREW BRYLOWSKI, MD
12300 FORD ROAD, SUITE 150
DALLAS, TX 75234

Respondent Name

DALLAS NATIONAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 20

MFDR Tracking Number

M4-10-3907-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As of today, May 3, 2010 our office has still not received an explanation of review and is unable to determine if there is any missing information Dallas National Insurance still needs to adjudicate the bill for the designated doctor exam that took place on October 13, 2009. After our many attempts to collect on this unpaid exam, Dr. Brylowski's office is now submitting the bill to Medical Dispute Resolution for assistance in collecting the full amount of the exam."

Amount in Dispute: $789.58

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No position summary was provided in response to MFDR.

Response Submitted by: Dallas National Insurance Company, 14160 Dallas Pkwy, Ste 500, Dallas, TX 75254

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 13, 2009	99456-W5 and 99082	$789.58	$500.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

No explanation of benefits was provided by either party.

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is there a provision for mileage reimbursement as billed by a DD in the Texas Labor Code or the Texas Administrative Code?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed the amount of $500.00 for CPT code 99456-W5 for DD examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). Review of the documentation supports that the doctor assigned MMI. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), the MAR for an IR using Diagnosis Related Estimates (DRE) Category II method on the lumbar is $150.00. The combined MMI/IR MAR is $500.00.
2. The requestor also billed $289.58 for CPT code 99082 for 495 miles for travel mileage reimbursement for the DD to travel between Dallas and San Antonio to perform the examination. Neither the Texas Labor Code nor the Texas Administrative Code have any provisions for reimbursement for such a service as billed by the DD. As it is out of the scope of MFDR, the CPT code will not be addressed further.
3. Respondent has not paid any amount on CPT code 99456-W5, therefore $500.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $500.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $500.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 27, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.